

**FUNCTIONAL ELIGIBILITY SCREEN
FOR CHILDREN'S LONG-TERM SUPPORT PROGRAMS**

INSTRUCTIONS: All dates should be entered as mm/dd/yyyy.

INDIVIDUAL INFORMATION

Screen Information

Name – Screening Agency	Screen Begin Date
Name – Screener	Date of Referral
Screen Type (Check only one box) <input type="checkbox"/> 01 Initial Screen <input type="checkbox"/> 02 Rescreen	Is this functional screen being completed for the purpose of determining Level of Care for a CLTS Waiver? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Answer "No" if a child is enrolled in a CLTS Waiver.</i>

Referral Source (check only one option)

<input type="checkbox"/> Parent(s)	<input type="checkbox"/> Children with Special Health Care Needs	<input type="checkbox"/> Psychologist
<input type="checkbox"/> Other Relative	<input type="checkbox"/> Family Support Program	<input type="checkbox"/> Public Health
<input type="checkbox"/> Guardian	<input type="checkbox"/> Foster Care	<input type="checkbox"/> School
<input type="checkbox"/> Self	<input type="checkbox"/> Hospital or Clinic	<input type="checkbox"/> Social Worker
<input type="checkbox"/> Audiologist	<input type="checkbox"/> Out-of-Home Setting	<input type="checkbox"/> Special Needs Adoption
<input type="checkbox"/> Birth-to-3 Program	<input type="checkbox"/> Physician / Clinic	<input type="checkbox"/> State Center
<input type="checkbox"/> Child Care Provider	<input type="checkbox"/> Psychiatrist	<input type="checkbox"/> Therapist—Physical, Occupational, or Speech
<input type="checkbox"/> Child Protective Services		<input type="checkbox"/> Other—Please specify: _____

Child's Basic Information

Name – Applicant (First)	(Middle)	(Last)	
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Social Security Number (###-##-####)	
Address			
City	State	Zip Code	Telephone – Home () -
County / Tribe of Residence		County / Tribe of Responsibility	

LIVING SITUATION

Current Residence of the Child (Check only one option)

<input type="checkbox"/> With Parent(s)	<input type="checkbox"/> Foster Care or Other Paid Caregiver's Home	<input type="checkbox"/> Nursing Home (includes rehabilitation facility if licensed as a nursing home)
<input type="checkbox"/> With Other Unpaid Family Member(s)	<input type="checkbox"/> Home / Apartment	<input type="checkbox"/> Treatment Foster Home
<input type="checkbox"/> With Legal Guardian	<input type="checkbox"/> DD Center / State Institution for Developmental Disabilities or ICF-MR	<input type="checkbox"/> With Live-in Caregiver(s)
<input type="checkbox"/> Adult Family Home	<input type="checkbox"/> Mental Health Institute / State Psychiatric Institution	<input type="checkbox"/> With Non-relatives / Roommates
<input type="checkbox"/> Alone	<input type="checkbox"/> No permanent residence	<input type="checkbox"/> Other—specify: _____
<input type="checkbox"/> Community Based Residential Facility (CBRF)		
<input type="checkbox"/> Child Caring Institution		
<input type="checkbox"/> Children's Group Foster Home		

If the child lives in a multiple bed complex, indicate

Number of residents (# of beds) certified for: _____

If the child is in an out of home placement, is the child expected to return home within six months of screening date?

☐ Yes ☐ No

LEGAL CONCERNS

Are the child's parents aware of the legal concerns (e.g., Guardianship, Power of Attorney, and Representative Payee) once the child turns 18 years of age?

☐ Yes ☐ No ☐ 18 or older

Is the child, who is 18 years of age or older, their own guardian (i.e., he/she does not have a legal guardian)?

☐ Yes ☐ No ☐ NA

CITIZENSHIP & IDENTITY INFORMATION

U.S. Citizenship

☐ Child has documentation to establish U.S. Citizenship—Verified by:

☐ U.S. Passport

☐ Certificate of Naturalization: N-550 / N-570

☐ Certificate of Citizenship: N-560 / N-561

☐ SSI-MA Recipient

☐ Medicare Recipient

☐ SSDI Recipient

☐ Birth Certificate

☐ Certification of Report of Birth: DS-1350

☐ Consular Report of Birth Abroad: FS-240

☐ Certification of Birth Abroad: FS-545

☐ Final Adoption Decree

☐ Medicaid Birth Claim

☐ Acquired citizenship through parents

☐ Hospital Record

☐ Child does not have U.S. Citizenship but does have the following Alien Registration Number per the verified Permanent Resident Card: _____ (xxx-xxx-xxx)

☐ Child claims to have U.S. Citizenship or an Alien Registration Number but required documentation was not provided.

☐ Child is only seeking eligibility for the Family Support Program, Community Options Program, Comprehensive Community Services, and / or Mental Health Wrap Around Program.

Identity was verified by:

☐ State or Territory Driver License

☐ School ID Card

☐ School Records

☐ Written Affidavit: F-10154

☐ Certificate of degree of Indian blood

☐ Certificate of degree of other U.S. American Indian

☐ Certificate of degree of Alaskan Native tribe

☐ ID issued by Federal, State, or local government

☐ Medical Record

☐ Institutional Care Affidavit: F-10175

☐ International driver's license

☐ Employee photo ID card

☐ Documentation pending

☐ Not a Medicaid Funded program

ETHNICITY & RACE

Ethnicity—Is participant Hispanic or Latino? ☐ Yes ☐ No

Race [Optional] (Check all boxes that apply)

☐ American Indian or Alaska Native

☐ Black or African American

☐ White

☐ Asian

☐ Native Hawaiian or Other Pacific Islander

INTERPRETER INFORMATION

If an interpreter is required, check language below (Check only one option)

☐ American Sign Language

☐ Hmong

☐ Other—Please specify: _____

☐ Spanish

☐ Russian

☐ Vietnamese

☐ A Native American Language

CONTACT INFORMATION**Contact Information 1**

Contact Type (check only one option)

☐ Parent☐ Non-Legally Responsible Relative☐ Guardian of Person☐ Power of Attorney☐ Representative Payee☐ Other—Specify: _____**If Power of Attorney, check all applicable types**☐ POA Education☐ POA Financial☐ POA Health Care

Name – Contact (First)

(MI)

(Last)

Address

City

State

Zip Code

Telephone – Home

() -

Telephone – Work

() -

Cell Phone

() -

☐ **Has legal rights to child's records**

Best time to contact and / or comments

Contact Information 2

Contact Type (check only one option)

☐ Parent☐ Non-Legally Responsible Relative☐ Guardian of Person☐ Power of Attorney☐ Representative Payee☐ Other—Specify: _____**If Power of Attorney, check all applicable types**☐ POA Education☐ POA Financial☐ POA Health Care

Name – Contact (First)

(MI)

(Last)

Address

City

State

Zip Code

Telephone – Home

() -

Telephone – Work

() -

Cell Phone

() -

☐ **Has legal rights to child's records**

Best time to contact and / or comments

Contact Information 3

Contact Type (check only one option)

☐ Parent☐ Non-Legally Responsible Relative☐ Guardian of Person☐ Power of Attorney →☐ Representative Payee☐ Other—Specify: _____**If Power of Attorney, check all applicable types**☐ POA Education☐ POA Financial☐ POA Health Care

Name – Contact (First)

(MI)

(Last)

Address

City

State

Zip Code

Telephone – Home

() -

Telephone – Work

() -

Cell Phone

() -

☐ **Has legal rights to child's records**

Best time to contact and / or comments

DIAGNOSES

Has the child been determined disabled by the Disability Determination Bureau (DDB) or by the Social Security Administration?

☐ Yes ☐ No ☐ Don't know

Transplanted Organ	Pending	Had on (mm/yyyy)	Transplanted Organ	Pending	Had on (mm/yyyy)
<input type="checkbox"/> Bone Marrow / Stem Cell	<input type="checkbox"/>	/	<input type="checkbox"/> Liver	<input type="checkbox"/>	/
<input type="checkbox"/> Heart	<input type="checkbox"/>	/	<input type="checkbox"/> Lung	<input type="checkbox"/>	/
<input type="checkbox"/> Intestine	<input type="checkbox"/>	/	<input type="checkbox"/> Pancreas	<input type="checkbox"/>	/
<input type="checkbox"/> Kidney	<input type="checkbox"/>	/			

Child's Diagnoses—Check all that apply and indicate if it is a PRESENTING diagnosis

A **PRESENTING diagnosis** by definition is a diagnosis that resulted in the child having needs that can be addressed through long term support services and will become the direct focus of a service plan for this child.

Diagnosis	Presenting diagnosis?	Diagnosis	Presenting diagnosis?
<input type="checkbox"/> Adjustment Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Impulse-Control Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Allergy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Infection—Current or Recurrent Infection	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Anemia (e.g., Sickle Cell, Fanconi's)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Limb Missing, Severe Limb Abnormality, Arthrogryposis	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Anorexia Nervosa, Bulimia, or Other Eating Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Liver Disease (Hepatic Failure, Cirrhosis)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Antisocial Personality Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Mental Health Diagnosis—Other—Specify: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Anxiety Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Metabolic Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Mood Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Asperger's Syndrome	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Multiple Sclerosis or ALS	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Muscular Dystrophy	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Attention-Deficit Disorder, Attention-Deficit Hyperactivity Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Muskuloskeletal Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Autism or Autism Spectrum	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Neuromuscular Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Bipolar Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Nutritional Imbalance (e.g., malnutrition, vitamin deficiency)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Blind or Severely Visually Impaired	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Obsessive-Compulsive Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Brain Disorder (other than seizures) or Brain Damage	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Oppositional Defiant Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Brain Injury—Traumatic (per statutory definition of TBI)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Paralysis other than Spinal Cord Injury	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Paralysis—Spinal Cord Injury	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Cardiac Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Personality Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Pervasive Developmental Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Cerebral Vascular Accident (CVA) (pre- or postnatal)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Pica	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Cognitive Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Polydipsia	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Conduct Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Post-Traumatic Stress or Acute Stress Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Congenital Abnormality	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Prader-Willi Syndrome	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Contractures / Connective Tissue Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Prematurity / Low Birth Weight	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Cystic Fibrosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Reactive Attachment Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Deaf or Severely Hearing Impaired	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Renal Failure or other Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Dehydration / Fluid or Electrolyte Imbalance	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Respiratory Condition (other than asthma)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Depersonalization Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Rett's Syndrome	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Schizoaffective Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Developmental Delay	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Schizophrenia or other Psychotic	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No		

<input type="checkbox"/> Digestive System Disorder (of mouth, esophagus, stomach, intestines, gall bladder, pancreas)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Disorder	
		<input type="checkbox"/> Seizure Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Sensory Disorder (other than Blind or Deaf)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Disruptive Behavior Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Dissociative Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Sexual and Gender Identity Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Down Syndrome – Mosaic or Translocation	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Skin Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Somatoform Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Down Syndrome – Trisomy 21	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Spina Bifida	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Dysthymic Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Spinal Muscular Atrophy	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Endocrine Disorder (not Diabetes)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Stereotypic Movement Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Failure to Thrive	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Substance Abuse Diagnosis—Other—Specify: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Fetal Alcohol Syndrome / Effects	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Genetic / Chromosomal Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Substance-Related Disorder, including Alcohol Abuse (not to include Caffeine or Nicotine Addictions)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Genitourinary System Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Hemophilia / Other Blood Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Tourette's Syndrome	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Hypochondriasis or Body Dysmorphic Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Trichotillomania	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Immune Deficiency	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Tuberous Sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Wound, Burn, Bedsore, Pressure Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No

PRIMARY CARE PHYSICIAN INFORMATION

Does the child have a provider that meets most of his / her medical needs (primary care physician)?

☐ Yes ☐ No

If applicant has a primary care physician, please indicate type of provider:

- | | |
|--|---|
| <input type="checkbox"/> Adult Physician (internist, gynecologist, adult specialist) | <input type="checkbox"/> Oncologist |
| <input type="checkbox"/> Family Practice Physician | <input type="checkbox"/> Pediatric Specialist |
| <input type="checkbox"/> General Practice Physician | <input type="checkbox"/> Pediatrician |
| <input type="checkbox"/> Neurologist | <input type="checkbox"/> Physician's Assistant |
| <input type="checkbox"/> Nurse Practitioner | <input type="checkbox"/> Psychiatrist |
| | <input type="checkbox"/> Other Type of Physician—Specify: _____ |

Notes (Include child's specific diagnoses for any general diagnostic category selected above.)

MENTAL HEALTH

Is child currently an adjudicated delinquent? ☐ Yes ☐ No

If the child has a clinical diagnosis of an emotional disability, has the diagnosis or symptoms related to that diagnosis, persisted for at least six months?

☐ Yes ☐ No ☐ Child does not have an emotional disability

If the child has a clinical diagnosis of an emotional disability, is the disability expected to last one year or longer?

☐ Yes ☐ No

Does the child have any of the following symptoms? (check all that apply and enter notes below)

- ☐ Anorexia / Bulimia—Life threatening symptomology
☐ Psychosis—Serious mental illness with delusions, hallucinations, and / or lost contact with reality
☐ Suicidality—Suicide attempt in past three months or significant suicidal ideation or plan in past month
☐ Violence—Life threatening acts
☐ No symptoms apply

Does the child currently require any of the following services? (check all that apply)

- ☐ Child protective services
☐ Clinical case management and service coordination across systems
☐ Criminal Justice system
☐ Mental health services
☐ Substance abuse services
☐ In-school supports for emotional and / or behavioral problems—Child has an Individualized Educational Plan (IEP) for Emotional/Behavioral Disorders (EBD) programming. Or the child has an active Behavioral Intervention Plan (BIP) in an IEP. Or the child requires behavioral intervention on a regular basis to avoid harm to themselves or others.
☐ No services required

If the child currently receives or needs any of the above services, are supports, or would supports be more than three hours / week combined?

☐ Yes ☐ No

Does this child exhibit disruptive behaviors in structured settings on a daily basis that require redirection from an adult at a frequency of every three minutes or more often AND this behavior has been demonstrated consistently for the past six months (do not count summer months)?

[Disruptive behaviors may include sliding around a room in a chair, screaming out inappropriate words or phrases, sitting in the center of a room and refusing to move.]

☐ Yes ☐ No

Does this child experience nightmares or night terrors at least four times a week AND this sleep interruption has been consistent for the past six months?

[These nightmares or night terrors must be characterized by repeated frightening episodes of intense anxiety that may be accompanied by screaming, crying, confusion, agitation, and / or disorientation.]

☐ Yes ☐ No

Is this child unable to complete routine events (hygiene tasks, leaving the house, walking on certain pavements, or sharing community equipment with others) throughout the day, every day, consistently for the past six months due to an obsession?

[An obsession is a thought, a fear, an idea, an image, or words that a child cannot get out of his / her mind. It does not include self stimulating or compulsive behaviors. The child experiencing the obsession must be aware of the obsession but not be able to control the influence of his / her own thought patterns.]

☐ Yes ☐ No

Notes (Include notes if Anorexia, Bulimia, Psychosis, Suicidality or Violence have been selected above)

BEHAVIORS****Current Intervention Reference Table**

Time-Out / Supervision	Medical / Professional Treatment	Emergency
<ul style="list-style-type: none"> Regular time-outs Restricted community access Constant supervision ("in-line of sight") 	<ul style="list-style-type: none"> Professional medical treatment Regular professional therapeutic treatment Regular use of protective gear Environmental restraints Constant supervision ("within arm's reach") 	<ul style="list-style-type: none"> Urgent or emergency medical treatment Police involvement

Child's Behavior (check all that apply)

Behavior	Frequency (over past 6 months)	Current Intervention** (see table above for information on options)	Expected to Last 6 Months or More?
High-Risk Behaviors			
Running Away	<input type="checkbox"/> Never <input type="checkbox"/> Less than once a month <input type="checkbox"/> 1-3 days each month <input type="checkbox"/> 1-3 days each week <input type="checkbox"/> 4 or more days each week	<input type="checkbox"/> None <input type="checkbox"/> Time-outs / Supervision <input type="checkbox"/> Medical / Professional Treatment <input type="checkbox"/> Emergency	<input type="checkbox"/> Yes <input type="checkbox"/> No
Substance Abuse	<input type="checkbox"/> Never <input type="checkbox"/> Less than once a month <input type="checkbox"/> 1-3 days each month <input type="checkbox"/> 1-3 days each week <input type="checkbox"/> 4 or more days each week	<input type="checkbox"/> None <input type="checkbox"/> Time-outs / Supervision <input type="checkbox"/> Medical / Professional Treatment <input type="checkbox"/> Emergency	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dangerous Sexual Contact	<input type="checkbox"/> Never <input type="checkbox"/> Less than once a month <input type="checkbox"/> 1-3 days each month <input type="checkbox"/> 1-3 days each week <input type="checkbox"/> 4 or more days each week	<input type="checkbox"/> None <input type="checkbox"/> Time-outs / Supervision <input type="checkbox"/> Medical / Professional Treatment <input type="checkbox"/> Emergency	<input type="checkbox"/> Yes <input type="checkbox"/> No
Use of Inhalants	<input type="checkbox"/> Never <input type="checkbox"/> Less than once a month <input type="checkbox"/> 1-3 days each month <input type="checkbox"/> 1-3 days each week <input type="checkbox"/> 4 or more days each week	<input type="checkbox"/> None <input type="checkbox"/> Time-outs / Supervision <input type="checkbox"/> Medical / Professional Treatment <input type="checkbox"/> Emergency	<input type="checkbox"/> Yes <input type="checkbox"/> No
Self-Injurious Behaviors			
Head-Banging	<input type="checkbox"/> Never <input type="checkbox"/> Less than once a month <input type="checkbox"/> 1-3 days each month <input type="checkbox"/> 1-3 days each week <input type="checkbox"/> 4 or more days each week	<input type="checkbox"/> None <input type="checkbox"/> Time-outs / Supervision <input type="checkbox"/> Medical / Professional Treatment <input type="checkbox"/> Emergency	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cutting or Burning or Strangulating Oneself	<input type="checkbox"/> Never <input type="checkbox"/> Less than once a month <input type="checkbox"/> 1-3 days each month <input type="checkbox"/> 1-3 days each week <input type="checkbox"/> 4 or more days each week	<input type="checkbox"/> None <input type="checkbox"/> Time-outs / Supervision <input type="checkbox"/> Medical / Professional Treatment <input type="checkbox"/> Emergency	<input type="checkbox"/> Yes <input type="checkbox"/> No
Biting Oneself Severely	<input type="checkbox"/> Never <input type="checkbox"/> Less than once a month <input type="checkbox"/> 1-3 days each month <input type="checkbox"/> 1-3 days each week <input type="checkbox"/> 4 or more days each week	<input type="checkbox"/> None <input type="checkbox"/> Time-outs / Supervision <input type="checkbox"/> Medical / Professional Treatment <input type="checkbox"/> Emergency	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tearing At or Out Body Parts	<input type="checkbox"/> Never <input type="checkbox"/> Less than once a month <input type="checkbox"/> 1-3 days each month <input type="checkbox"/> 1-3 days each week <input type="checkbox"/> 4 or more days each week	<input type="checkbox"/> None <input type="checkbox"/> Time-outs / Supervision <input type="checkbox"/> Medical / Professional Treatment <input type="checkbox"/> Emergency	<input type="checkbox"/> Yes <input type="checkbox"/> No
Inserting Harmful Objects Into Body Orifices	<input type="checkbox"/> Never <input type="checkbox"/> Less than once a month <input type="checkbox"/> 1-3 days each month <input type="checkbox"/> 1-3 days each week <input type="checkbox"/> 4 or more days each week	<input type="checkbox"/> None <input type="checkbox"/> Time-outs / Supervision <input type="checkbox"/> Medical / Professional Treatment <input type="checkbox"/> Emergency	<input type="checkbox"/> Yes <input type="checkbox"/> No

Behavior	Frequency (over past 6 months)	Current Intervention** (see table above for information on options)	Expected to Last 6 Months or More?
Aggressive or Offensive Behaviors			
Verbal Abuse	<input type="checkbox"/> Never <input type="checkbox"/> Less than once a month <input type="checkbox"/> 1-3 days each month <input type="checkbox"/> 1-3 days each week <input type="checkbox"/> 4 or more days each week	<input type="checkbox"/> None <input type="checkbox"/> Time-outs / Supervision <input type="checkbox"/> Medical / Professional Treatment <input type="checkbox"/> Emergency	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hitting, Biting, Kicking	<input type="checkbox"/> Never <input type="checkbox"/> Less than once a month <input type="checkbox"/> 1-3 days each month <input type="checkbox"/> 1-3 days each week <input type="checkbox"/> 4 or more days each week	<input type="checkbox"/> None <input type="checkbox"/> Time-outs / Supervision <input type="checkbox"/> Medical / Professional Treatment <input type="checkbox"/> Emergency	<input type="checkbox"/> Yes <input type="checkbox"/> No
Masturbating in Public	<input type="checkbox"/> Never <input type="checkbox"/> Less than once a month <input type="checkbox"/> 1-3 days each month <input type="checkbox"/> 1-3 days each week <input type="checkbox"/> 4 or more days each week	<input type="checkbox"/> None <input type="checkbox"/> Time-outs / Supervision <input type="checkbox"/> Medical / Professional Treatment <input type="checkbox"/> Emergency	<input type="checkbox"/> Yes <input type="checkbox"/> No
Urinating on Another or Smearing Feces	<input type="checkbox"/> Never <input type="checkbox"/> Less than once a month <input type="checkbox"/> 1-3 days each month <input type="checkbox"/> 1-3 days each week <input type="checkbox"/> 4 or more days each week	<input type="checkbox"/> None <input type="checkbox"/> Time-outs / Supervision <input type="checkbox"/> Medical / Professional Treatment <input type="checkbox"/> Emergency	<input type="checkbox"/> Yes <input type="checkbox"/> No
Serious Threats of Violence	<input type="checkbox"/> Never <input type="checkbox"/> Less than once a month <input type="checkbox"/> 1-3 days each month <input type="checkbox"/> 1-3 days each week <input type="checkbox"/> 4 or more days each week	<input type="checkbox"/> None <input type="checkbox"/> Time-outs / Supervision <input type="checkbox"/> Medical / Professional Treatment <input type="checkbox"/> Emergency	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sexually Inappropriate Behavior Toward Children or Adults	<input type="checkbox"/> Never <input type="checkbox"/> Less than once a month <input type="checkbox"/> 1-3 days each month <input type="checkbox"/> 1-3 days each week <input type="checkbox"/> 4 or more days each week	<input type="checkbox"/> None <input type="checkbox"/> Time-outs / Supervision <input type="checkbox"/> Medical / Professional Treatment <input type="checkbox"/> Emergency	<input type="checkbox"/> Yes <input type="checkbox"/> No
Abuse or Torture of Animals	<input type="checkbox"/> Never <input type="checkbox"/> Less than once a month <input type="checkbox"/> 1-3 days each month <input type="checkbox"/> 1-3 days each week <input type="checkbox"/> 4 or more days each week	<input type="checkbox"/> None <input type="checkbox"/> Time-outs / Supervision <input type="checkbox"/> Medical / Professional Treatment <input type="checkbox"/> Emergency	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lack of Behavioral Controls			
Destruction of Property / Vandalism	<input type="checkbox"/> Never <input type="checkbox"/> Less than once a month <input type="checkbox"/> 1-3 days each month <input type="checkbox"/> 1-3 days each week <input type="checkbox"/> 4 or more days each week	<input type="checkbox"/> None <input type="checkbox"/> Time-outs / Supervision <input type="checkbox"/> Medical / Professional Treatment <input type="checkbox"/> Emergency	<input type="checkbox"/> Yes <input type="checkbox"/> No
Stealing, Burglary or Kleptomania within the Community	<input type="checkbox"/> Never <input type="checkbox"/> Less than once a month <input type="checkbox"/> 1-3 days each month <input type="checkbox"/> 1-3 days each week <input type="checkbox"/> 4 or more days each week	<input type="checkbox"/> None <input type="checkbox"/> Time-outs / Supervision <input type="checkbox"/> Medical / Professional Treatment <input type="checkbox"/> Emergency	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other (list): _____	<input type="checkbox"/> Never <input type="checkbox"/> Less than once a month <input type="checkbox"/> 1-3 days each month <input type="checkbox"/> 1-3 days each week <input type="checkbox"/> 4 or more days each week	<input type="checkbox"/> None <input type="checkbox"/> Time-outs / Supervision <input type="checkbox"/> Medical / Professional Treatment <input type="checkbox"/> Emergency	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> None of the behavioral problems apply at this time.			

Notes (Describe specific behavior and intervention when one of the behaviors above has been selected)

ACTIVITIES OF DAILY LIVING (ADLS) AND INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLS)*Refer to separate forms containing age-specific ADL and IADL questions.***SCHOOL AND WORK****Does the child's physical health or stamina level cause the child to miss over 50 percent of school or classes, or to require home education?**☐ Yes ☐ No ☐ NA**Does the child's behavior or emotional needs result in failing grades, repeated truancy and / or expulsion, suspension, and / or an inability to conform to school or work schedule more than 50 percent of the time?**☐ Yes ☐ No ☐ NA**Is the child currently attending high school?**☐ Yes ☐ No ☐ NA**What year is the child expected to leave school?**

Year (yyyy): _____

The following types of supports are expected for the child to prepare for leaving school (check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Section 504 Plan |
| <input type="checkbox"/> Not known at this time | <input type="checkbox"/> Transition Individual Education Plan (TIEP) |
| <input type="checkbox"/> Benefit Specialist | <input type="checkbox"/> Transition Services from the County |
| <input type="checkbox"/> Division of Vocational Rehabilitation (DVR) | <input type="checkbox"/> Other expected supports—Specify: _____ |

Current Employment Status☐ Not employed ☐ Employed full-time ☐ Employed part-time**Employment Interest**☐ Interested in a new job ☐ Not interested in a new job**If Employed, where? (check all that apply)**

- | | |
|---|--|
| <input type="checkbox"/> Attends pre-vocational day / work activity program | <input type="checkbox"/> Has paid job in the community |
| <input type="checkbox"/> Attends sheltered workshop | <input type="checkbox"/> Works at home |

Need for Assistance to Work (optional for unemployed persons)

- | | |
|--|---|
| <input type="checkbox"/> Independent (with assistive devices if uses them) | <input type="checkbox"/> Needs help every day but does not need the continuous presence of another person |
| <input type="checkbox"/> Needs help weekly or less (e.g., if problems arise) | <input type="checkbox"/> Needs the continuous presence of another person |

Notes:

HEALTH RELATED SERVICES**Medical or Skilled Nursing Needs (check all that apply)**

Expected to last, at this frequency, and child is not expected to become independent at this task for at least six months or more

<input type="checkbox"/> Recurrent cancer / Date of Recurrence: _____ (mm/dd/yyyy)	
<input type="checkbox"/> Stage IV cancer / Date of Stage IV Diagnosis: _____ (mm/dd/yyyy)	
<input type="checkbox"/> Terminal condition (verified prognosis < 12 months)	
<input type="checkbox"/> Rehabilitation program for brain injury or coma—minimum 15 hours / week	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Unable to turn self in bed or reposition self in wheelchair	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Tracheostomy	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Ventilator (positive pressure)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> PT, OT, or SLP by therapist (does not include behavioral problems) <input type="checkbox"/> Less than six sessions / week <input type="checkbox"/> Six or more sessions / week	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> PT, OT, or SLP therapy follow-through: exercise, sensory stim, stander, serial splinting / casting, braces, orthotics <input type="checkbox"/> One hour a day or less <input type="checkbox"/> More than one hour / day	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Wound, site care or special skin care <input type="checkbox"/> One hour a day or less <input type="checkbox"/> More than one hour / day	<input type="checkbox"/> Yes <input type="checkbox"/> No

Place one checkmark per any row that applies

Health-Related Services Needed	Frequency of Help / Services Needed						Expected to last, at this frequency, and child is not expected to become independent at this task for at least six months or more
	NA	In-depend	1 - 3 times / month	1 - 3 times / week	4 - 7 times / week	2 or more times / day	
BOWEL or OSTOMY related SKILLED tasks: digital stim, changing wafer, irrigation (does not include site care).							<input type="checkbox"/> Yes <input type="checkbox"/> No
DIALYSIS: hemodialysis or peritoneal, in home or at clinic							<input type="checkbox"/> Yes <input type="checkbox"/> No
IVs—peripheral or central lines: fluids, medications, and transfusions (does not include site care)							<input type="checkbox"/> Yes <input type="checkbox"/> No
OXYGEN and/or deep SUCTIONING—with oxygen to include only SKILLED tasks such as titrating oxygen, checking blood saturation levels, etc.							<input type="checkbox"/> Yes <input type="checkbox"/> No
RESPIRATORY TREATMENTS: chest PT, C-PAP, Bi-PAP, IPPB treatments (does not include inhalers or nebulizers)							<input type="checkbox"/> Yes <input type="checkbox"/> No
TPN (Total Parenteral Nutrition), does not include site care							<input type="checkbox"/> Yes <input type="checkbox"/> No
TUBE FEEDINGS (does not include site care)							<input type="checkbox"/> Yes <input type="checkbox"/> No
URINARY CATHETER-RELATED SKILLED TASKS: straight caths, irrigations, instilling meds (does not include site care)							<input type="checkbox"/> Yes <input type="checkbox"/> No

Notes:

SCREEN COMPLETION TIME**Date of Screen Completion** (mm/dd/yyyy): _____

Time to Complete Screen	Hours	Minutes
Face-to-face contact with the applicant		
Collateral Contacts		
Paper Work		
Travel Time		
Total Time to Complete Screen		

Screen Notes:

(Please use this format [MM/DD/YY: Comments. Initials/Program Affiliation]. Put most recent notes at the top.)

TRANSFER INFORMATION

To be completed after eligibility determination if applicant is referred to another program.

Date of Referral to Service Agency

Name – Service Agency